kidney. This abscess was partly enclosed by the kidney substance and partly by surrounding perinephric fat. It also appeared to be draining into the pelvis of the kidney but there was no real suppuration of the pelvis or of the kidney substance.

The brain (1,407 grams) was of normal size and on sectioning nothing unusual could be found by naked eye examination. The cord was grossly normal.

Histology of the Cord and Brain

The lumbar cord shows much demyelinization with little cellular reaction now visible. The affected areas are widespread and somewhat patchy in distribution but seem to be favouring the anterior part of the cord more than the posterior. A little perivascular cuffing with lymphocytes is present. There is little evidence of gliosis.

The appearances seen in the cervical portion of the cord are similar but here a cellular reaction is taking place and many histiocytes with foamy cytoplasm are visible. In the medullary region of the brain stem a similar process is present but this is more patchy and somewhat less diffuse than that seen in the spinal cord.

Many areas of the brain show patches of demyelinization. Some of these are at different stages. In the more recent ones there is a fairly marked cellular reaction and numerous phagocytes are seen and there is much perivascular cuffing. In the later ones little cellular reaction is visible and in one or two areas almost complete liquefaction of the brain substance appears to have occurred.

Summary

The pathologist's report is that of a diffuse encephalo-myelitis of unknown etiology. Clinically the patient presented the picture of neuromyelitis optica. There is no "definitive" pathology, the diagnosis is made purely from the symptom-complex. The absence of gliosis in this case rules out multiple sclerosis pathologically but this disease cannot be separated from diffuse encephalo-myelitis *per se* except for the additional single clinical sign of visual disturbance. The probability that this is a distinctive and separate disease entity from diffuse encephalo-myelitis is doubtful.

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A CASE OF DOUBLE UTERUS

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The following case was felt to be of interest on account of its rarity.

Mrs. E. J. McK. was referred to us with symptoms of extensive menorrhagia accompanied by severe lower abdominal cramps. There had been a gradual onset two to three years ago with gradually increasing menorrhagia and low abdominal cramps. During the last six months her condition had become much worse. These bouts now lasted two to three weeks each month and she was either confined to bed, or, on two occasions, was in hospital due to pain and debility from blood loss. Her menses started at about 12 and there was nothing abnormal until seven years ago, when, during an apparently normal pregnancy, she had premature labour at seven months. The baby weighed 3 lb. 13 oz. and died in its eighth day. No more details could be found regarding this confinement. A general functional inquiry revealed nothing significant except an operation in 1948 for diseased gall bladder and appendix.

The general physical examination revealed some tenderness suprapubically and in both lower quadrants of the abdomen, but no masses were felt. An upper right rectus incision was noted. On inspection of the pelvis, anterior and posterior mid-line tags of mucosa were noted in the vagina and a septum running about an inch deep in the A.P. diameter was seen in the upper aspect of the vagina. Two distinct, separate cervices were noted, one on either side of the septum. On bimanual examination, two separate uterine bodies were vaguely felt. At this time her hæmoglobin was 64%, blood type A, Rh positive. This followed immediately after a transfusion she had had before referral. The urine showed no abnormalities.

Under anæsthetic, a probe was found to pass freely into the right uterine body and cervix but not past the internal cervical os on the left side. A connection between the two cavities was seen in the region of the internal cervical os. Definite sausage-shaped uteri were felt in the fornices in the form of a U. These were well anteverted and symmetrical.

At laparotomy, a U-shaped fusiform uterus was found with a flap of bladder triangularly shaped attached at the apex of the triangle over the base of the U of the body of the uterus and attached to the posterior aspect of it. A total hysterectomy was done. A plastic repair was felt inadvisable due to the possibility of a ruptured uterus with subsequent pregnancy because of the connection between the two cervical canals. No serious difficulty was incurred after the bladder flap was freed. A rather extensive incision was necessary in the vault of the vagina and the septum in the vagina was removed with the double cervix. A routine closure with oversewing of the fascia of the vaginal cuff was done. No complication occurred and she had an uneventful postoperative course.

Pathological report.—(Dr. D. F. Moore). Gross specimen consists of a double uterus with two exocervical openings. It weighs 104 grams and each corpus possesses one laterally-placed cornu with a tubal and round ligament stump. The left corpus measures 8 cm. from fundus to exocervix, 4 cm. in transverse diameter and 3 cm. in thickness. The right corpus measures 7.5 x 3.4 x 3 cm. Through separate cervical canals a probe can be passed readily to either fundus. The fused cervices measure 3 cm. in length x 5 cm. in transverse diameter x 2.5 cm. in thickness. A 1 cm. communication extends between two cervical canals and begins 1 cm. above the ora. Removal of the attachment of a vaginal septum reveals a raw strip, 0.4 cm. in greatest width, lying between two external ora. No sections are taken because the specimen is to be preserved for museum purposes.

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DISCUSSION

The case presented was one of a complete double uterus, the only connection being at the internal os of the cervices and this probably of traumatic origin. The condition is the consequence of an error of development of the Mullerian system particularly of the fusion of the lower parts to form one canal which later forms uterus, cervix and upper vagina. Bilateral or unilateral failure of development may occur. According to Wm. Hunter,[1] arrested development of one or both sides during the second month of interuterine life may cause the growth of a dichotomous, bicornuate or cordiform uterus with a double uterine cavity. In all cases the deformed uterus arises from two, or, in the case of the unicornuate uterus, one Mullerian duct, and each semi-uterus has only one associated uterine tube and ovary. Many cases are symptomless. The cervices do not show any abnormality from a normal cervix, and it is possible in an undiagnosed case to curette one uterine body and completely miss an incomplete abortion or carcinoma in an unexplored horn. The above author states that operation on a completely double uterus is not justifiable simply for correction of the uterine deformity, but is done to cure debility from pain and heavy blood loss. The discussed case is an example of the latter.

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A GIANT MELANOTIC MOLE

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THIS CASE is reported because of the unusually extensive size and the character of the mole (Fig. 1). The patient was first seen by one of us (R.K.D.), when a year old, and after the mother had undressed the child the doctor stopped himself as he was about to request that she remove the child's coat—the "coat" being the mole in question. It extended at that time from within the hairline at the nape of the neck to the second lumbar spine inferiorly, and from the anterior axillary line on the one side right round to the corresponding line on the other. The mother explained that she had just had an extensive study done on the child at the Sick Children's Hospital at Toronto, and they had advised against operation as the child was not expected to grow up. The tumour was present at birth, and had not varied in relative size since then.

The patient had a younger sister with rather more moles than normal; they were of the same type.

From time to time the patient was seen by one of us, as family doctor, and palliative treatment prescribed. The main complaint was that of intolerable itching—the patient would almost at times seem to scratch herself to pieces. This pruritus was most marked superiorly, and along the edges of the tumour. The tumour mass itself was rolled into folds, and radiographically there was a faint calcium deposit throughout which showed on chest films as outlining the respective folds as they hung from the body. Luminal in small doses seemed to control the pruritus best, and was least habit-forming. The child was bright in school, and in due time it was decided

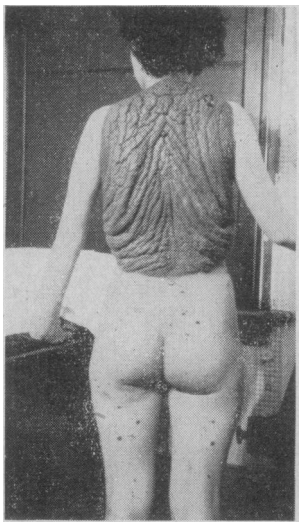

Fig. 1

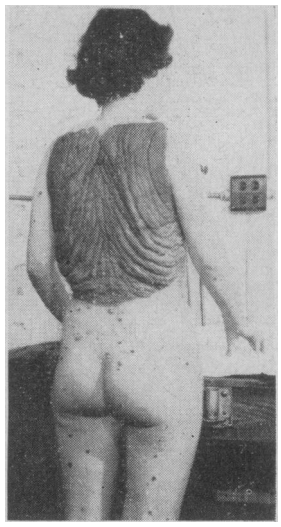

Fig. 2

Fig. 1.—Patient, aged 15, showing giant mole extending across the back. Note the numerous moles throughout the skin areas apart from the main tumour mass itself. Photo before operation. Fig. 2.—Patient, aged 16, nine months after operation. Shows a distinct hair-line now, with the "V"-shaped depression at top of mole in midline where tumour tissue sloughed after operation.